MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES
BUREAU OF CHILD CARE

CHILD ENROLLMENT

CHILD'S NAME	SEX	BIRTHDATE

ADDRESS (STREET, CITY, STATE, ZIP CODE)	HOME TELEPHONE NUMBER
	( )

OPTIONAL

SCHOOL CHILD ATTENDS

NAME	TELEPHONE NUMBER
	( )

ADDRESS (STREET, CITY, STATE, ZIP CODE)

IDENTIFYING INFORMATION

A) MOTHER'S OR GUARDIAN'S NAME	HOME TELEPHONE NUMBER
	( )

ADDRESS (☐ SAME AS CHILD/OR STREET, CITY, STATE, ZIP CODE)

EMPLOYED BY (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO

ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER
	( )

B) FATHER'S OR GUARDIAN'S NAME	HOME TELEPHONE NUMBER
	( )

ADDRESS (☐ SAME AS CHILD/OR STREET, CITY, STATE, ZIP CODE)

EMPLOYED BY (OR SCHOOL ATTENDED)	HOURS OF EMPLOYMENT FROM TO

ADDRESS (STREET, CITY, STATE, ZIP CODE)	BUSINESS TELEPHONE NUMBER ( )

EMERGENCY CONTACT(S) (OTHER THAN PARENT(S) OR DOCTOR) AT LEAST ONE REQUIRED

NAME	TELEPHONE NUMBER
	( )

ADDRESS (STREET, CITY, STATE, ZIP CODE)	RELATIONSHIP

OPTIONAL

NAME	TELEPHONE NUMBER
	( )

ADDRESS (STREET, CITY, STATE, ZIP CODE)	RELATIONSHIP

PERSON(S) AUTHORIZED TO TAKE CHILD FROM THE CHILD CARE FACILITY:

NAME	NAME

COMMENTS ON CHILD'S DEVELOPMENT

(NOTE ALLERGIES, HABITS, SPECIAL LANGUAGE, ETC.)

TO BE COMPLETED BY CHILD CARE FACILITY

ADMISSION DATE

ENROLLED FOR (DAYS OF WEEK)

HOURS PER DAY FROM TO

DISCHARGE DATE (TO BE RETAINED FOR ONE YEAR AFTER DISCHARGE)

AUTHORIZATION FOR EMERGENCY MEDICAL CARE

I understand that I will be notified at once in case of accident or illness to my child, and I will make arrangements for medical care of my child with the physician or hospital of my choice.

If I cannot be reached to make necessary arrangements, or in a critical emergency requiring medical care, I hereby authorize _____
PROVIDER

(Please list name & phone # of doctor, hospital or both)

To Contact Doctor/Clinic:

NAME	TELEPHONE
	( )

ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL

For Emergency Medical Treatment Of My Child, My Preferred Hospital Is:

NAME	TELEPHONE
	( )

ADDRESS (STREET, CITY, STATE, ZIP CODE) - OPTIONAL

TRIP AND ACTIVITY PERMISSION

I ☐ do ☐ do not give consent for my child to take part in field trips or excursions with this child care facility under proper supervision.

I understand I will be notified when such trips are planned and that I must give written permission for each field trip or excursion.

I ☐ do ☐ do not give permission for the facility to transport my child to and from school.

NAME OF SCHOOL	ADDRESS

AGREEMENTS

a) The provider and I have agreed on a plan for continuing communication regarding my child's development, behavior etc.

b) When my child is ill, it is understood and agreed that s/he may not be accepted for care.

c) I have received a copy of this facility's policies pertaining to the admission, care and discharge of children.

d) I have been informed that a copy of the Licensing Rules for Family Child Care Homes/Licensing Rules for Group Child Care Homes/Licensing Rules for Child Care Centers in Missouri is available at this facility for review.

PARENT/LEGAL GUARDIAN SIGNATURE ►	DATE

HEALTH REPORT FOR SCHOOL-AGE CHILD

CHILD'S HEALTH HISTORY AND CURRENT HEALTH PROBLEMS

ANY ALLERGIES, SPECIAL MEDICAL CONDITIONS, INCLUDING CHRONIC HEALTH PROBLEMS:

ANY SPECIAL MEDICATIONS AND/OR RESTRICTIONS:

THIS CERTIFIES THAT MY CHILD IS, TO MY KNOWLEDGE, IN GOOD HEALTH AND FREE OF DISABILITIES THAT WOULD ENDANGER HIM/HER OR OTHER CHILD IN DAY CARE.	PARENT OR LEGAL GUARDIAN SIGNATURE ►	DATE